

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013814

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2851

VS-300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b.

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION

Homer G. Phillips

Inside Limits  
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

c. CITY

St. Louis

d. STREET  
ADDRESS

1426 No. Grand

Inside Limits  
Yes ☐ No ☐

Reside on Farm  
Yes ☐ No ☐

3. NAME OF DECEASED  
(Type or print)

First  
Mattie

Middle

Last  
Scott

4. DATE  
OF  
DEATH

Month  
3

Day  
8

Year  
63

5. SEX

Fem.

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

12-23-1914

9. AGE (last birthday)

48

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (City and state or country)

Mississippi

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

James L. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

17. INFORMANT

James L. Scott-1426 No. Grand Ave.

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Embolism, Multiple

INTERVAL BETWEEN  
ONSET AND DEATH  
Undet.

DUE TO (b)

Pelvic Abscess

DUE TO (c)

Uterine Myomata

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Chronic Pelvic Inflammatory Disease

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☒ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour  
a.m.  
p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

2-21-63

to 3-8-63

and last saw her alive on 3-8-63

Death occurred at

6:15 P.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Name or title)

22b. ADDRESS

2601 N. Whittier

22c. DATE SIGNED

3-11-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

3-14-1963

23c. NAME OF CEMETERY OR CREMATORY

National Cemetery

23d. LOCATION (City, town, or county)

St. Louis (County) Missouri

24. FUNERAL DIRECTOR

ADDRESS

Ellis Funeral Home-2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.

MAR 11 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK

OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4198

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.